2012 Local Educational Agency (LEA)

Medi-Cal Billing Option Program Training
Frequently Asked Questions (FAQs)

Q1. Where can LEA providers get the ICD-9 codes for the diagnosis code box on the claim form?

A. The LEA Provider Manual, Section loc ed bil contains information on how to obtain the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9) code book:

Ingenix
P. O. Box 27116
Salt Lake City, UT 84127-0116
1-800-INGENIX (464-3649), 1-800-765-6588 (Customer Service), or
PMIC (Practice Management Information Corporation)
Order Processing Department
4727 Wilshire Blvd., Suite 300
Los Angeles, CA 90010-3894
1-800-MED-SHOP (633-7467) Monday-Friday 8:30 a.m. – 5:00 p.m. (CST)

Q2. Our private school develops Individual Services Plans (as opposed to IEPs) for students with disabilities that will receive services through the school district during the year. Are consultations between school district staff and the private school teachers billable to Medi-Cal?

A. No, the LEA Medi-Cal Billing Option Program only reimburses LEAs for direct health care services provided to Medi-Cal eligible students. Consultation between staff members is not a billable service.

Q3. Are there guidelines that specify how to reinvest LEA Medi-Cal Billing Option Program reimbursement? What are considered allowable and unallowable ways to spend LEA reimbursement money?

A. Any federal funds received by an LEA provider for LEA services shall be reinvested in services for school children and their families. These funds shall be used to supplement, not supplant, existing services. School-linked support services for children and families consist of services such as case-managed health, mental health, social, and academic support services benefiting children and their families. The services are intended to benefit children and their families and may include, examples originally outlined in SB 620, and now found in California Education Code, Section 8804(g).

Q4. Who should the LEA collaborative consist of? Can a non-school district employee be included in the collaborative?

A. The interagency collaborative shall consist of at least three individuals with varying interest in the reinvestment of funds for the LEA Program. The collaborative membership shall involve, generally, representation will include the schools, major public agencies service children and families, including health, mental health, social services, and juvenile justice, the courts, civic and business leadership, the advocacy community, parents or guardians, current safety net and traditional health care providers, and LEA fiscal business staff. Additional information can be found in Welfare and Institutions Code, commencing with Section 18986 and the LEA Collaborative as specified in California Education Code, commencing with section 8806.

Q5. Does the LEA Medi-Cal Billing Option Program reimburse for social skills training provided by a Speech-Language Pathologist?

A. The LEA Medi-Cal Billing Option Program reimburses for direct health care services. At this time, social skills training is not a reimbursable service. Please refer to the loc ed serv spe section of the LEA Provider Manual for a description of speech therapy services.

Q6. Are speech therapists with a waiver allowed to bill?

A. No, speech-language pathologists who have a waiver are not qualified to bill speech therapy services under the LEA Medi-Cal Billing Option Program. Speech-language pathologists must meet the licensing and/or credentialing requirements as specified in the LEA Medi-Cal Billing Option Program Provider Manual (loc ed rend and loc ed serv spe).

Q7. Where can I find information on how to utilize the Medi-Cal web portal Point of Service (POS) system instead of the data tape match?

A. LEAs that want to utilize the data tape match system must submit a Data Usage Agreement (DUA) to the LEA Medi-Cal Billing Option Program. For information regarding other available methods to determine a beneficiary's eligibility, go to: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/elect_z01.doc. The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows you to verify recipient eligibility through a touch-tone telephone. For more information about AEVS go to: http://files.medi-cal.ca.gov/pubsdoco/AEVS_home.asp. The Point of Service (POS) device has swipe capabilities for all plastic identification cards associated with programs served by DHCS Fiscal Intermediary and allows you to verify recipient eligibility. For more information about POS go to:http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/point_z01.doc.

Q8. Who is required to fill out the DUA? We use a billing service.

A. The DUA agreement is ultimately the responsibility of the billing LEA or Consortium whose NPI number is used for billing (User) so this billing LEA or Consortium will fill out and sign the DUA. If the billing LEA uses a billing service, the billing LEA must have a written agreement with the billing service that imposes the same privacy and security controls on the billing service that the billing LEA has under the DUA. The billing service may also be required to sign the DUA if they are the "Custodians of the Files" on behalf of the User.

Q9. Please define the method(s) required to properly destruct electronic files. The Data Usage Agreement specifies Department of Defense methods; what does this mean?

A. The Security Controls specify that electronic files shall be destroyed using the Gutmann or U.S. Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. There are several types of software, which meet these standards, and DHCS does not require that any specific one be used. The DHCS Information Security Office (ISO) will respond to inquiries as to whether a specific software meets these standards. If a method of destruction other than one specified in the Security Controls is to be used, the prior written permission of the DHCS ISO is needed.

Q10. Can the custodian comply with the Data Use Agreement (DUA) rules on behalf of the LEA if that LEA never directly participates in the "creation, receipt, maintenance, transmittal (or) disclosure of data from DHCS containing PHI or PI"?

A. Yes. The custodian named in an LEA's DUA should have the power to act on behalf of the LEA in matters regarding the data. These individuals are responsible for implementing the DUA's provisions, including privacy and security controls. The custodian should have a formal written agreement with the LEA.

Q11. What if billing begins in the middle of the school year? Can the DUA be turned in after 11/30/2012?

A. The DUA needs to be submitted prior to the User or Custodian of Files receiving tape match data. It may be submitted in the middle of the year; however, no tape match data will be processed until it is submitted to DHCS.

Q12. What is the CRCS post audit settlement process? How will we be able to identify the CRCS overpayment/underpayment?

A. Once A&I's Audit and Review Analysis Section (ARAS) receives the CRCS settlement amounts due to the provider/State from the A&I Financial Audit Branch (FAB), ARAS will process an Action Notice and send to Xerox, DHCS' Fiscal Intermediary and DHCS' Third Party Liability and Recovery Division.

- If the CRCS results in an overpayment, Xerox will offset any amount due to the State through the billing/payment process. This will be reflected on the Provider's Remittance Advice Report(s) as RAD Code 710 "payment to provider of final cost settlement."
- If the CRCS results in an underpayment and funds are due to the provider, LEAs will receive a "Statement of Account Status" letter from Xerox, which will identify the anticipated amount and check date for the additional reimbursement. The additional payment will be included in the check attached to your Medi-Cal Financial Summary and identified on line 8 (A/R Payments). The last page of your RAD will identify this payment with RAD Code 710 "payment to provider of final cost settlement."

Q13. Can a school district bill the LEA Medi-Cal Billing Option Program for psychology/counseling services provided by a graduate student (for example, a marriage and family therapist intern or associate social worker) who is supervised by a licensed and/or credentialed practitioner.

A. No. Psychology/counseling services provided by graduate students, such as a marriage and family therapist intern or associate social worker, are not billable under the LEA Medi-Cal Billing Option Program. Qualified practitioners who may provide psychology/counseling services can be found in LEA Medi-Cal Billing Option Provider Manual loc ed bil pages 6 and 7 and loc ed serv psych page 2. Qualified practitioners must meet the necessary licensing and/or credentialing requirements as specified in the LEA Provider Manual section titled loc ed rend.

Q14. Is there a reason that the billable amount on the claim should be based on the maximum allowable amount, versus only the amount the federal government will pay?

A. LEAs may submit 50 percent of the maximum allowable reimbursement rates identified in the LEA Medi-Cal Billing Option Program provider manual. However, since the LEA Medi-Cal Billing Option Program must annually inflate interim reimbursement rates and will rebase interim reimbursement rates periodically, which is done retroactively through the EPC process, LEAs may want to submit claims for the maximum allowable rate. Medi-Cal will only reimburse up to the charge or maximum allowable rate multiplied by the FMAP, whichever is less.

Q15. Can other school staff provide TCM assistance activities under the direct supervision of the qualified case manager?

A. Qualified practitioners who may provide TCM services can be found in LEA Medi-Cal Billing Option Provider Manual loc ed rend page 1 and loc ed serv targ page 5.

Q16. What address do we send a TCM labor survey to?

A. Department of Health Care Services
Safety Net Financing Division
LEA Medi-Cal Billing Option
1501 Capitol Avenue, MS 4603, P.O. Box 997436
Sacramento, CA 95899-7436
* This address is listed on TCM page on the LEA website

Q17. Does the PPL12-012 cover MAA only or does this apply to Direct Billing costs as well?

A. The purpose of Policy and Procedure Letter (PPL) 12-012 is to reiterate federal and state policy regarding the prohibition on claiming Federal Financial Participation (FFP) for contingency fee contracts. According to the Centers for Medicare and Medicaid Services (CMS), Medicaid claims for the costs of administrative activities and direct medical services may not include fees for consultant services that are contingent upon recovery of costs from the Federal Government.

Q18. What are the supervision requirements for the different SLP credentials?

A. 1. SLPs with a professional clear services credential in speech-language pathology do not require supervision. These credentialed practitioners are qualified to supervise other credentialed SLP practitioners.

2). SLPs with a preliminary services credential in speech-language pathology do not require supervision. These credentialed practitioners are not qualified to supervise other credentialed SLP practitioners.

3). SLPs with a clinical or rehabilitative services credential with an authorization in language, speech and hearing require supervision.*

4). SLPs with a valid CCTC credential issued prior to the above credentials require supervision.*

*Note: Credentialed practitioners can upgrade to the newer professional clear services credential by meeting CCTC requirements.

Please refer to the LEA Provider Manual loc ed rend and loc ed serv spe for specific information regarding practitioner qualifications and supervision requirements.

Q19. Will a physician's telephone orders for G-tube feeding, diabetic care, etc. suffice for OT/PT treatment documentation?

A. No, a written prescription is required for physical therapy and occupational therapy treatments. At a minimum, the prescription must identify: school name, student's name, practitioner observations and reason for treatment, type of practitioner, and signature of practitioner. The documentation should be maintained in the student's files.

Q20. What is an example of an encounter-based treatment service?

A. There is only one encounter-based treatment service that is reimbursable under the LEA Medi-Cal Billing Option Program; that treatment is an IEP/IFSP hearing check.

Q21. Does the speech protocol take the place of having an individual referral authorizing speech therapy services?

A. A physician-based standards protocol may be developed and used to document medical necessity of speech and audiology treatment services to meet California State requirements that a written referral be provided by a physician or dentist. The protocol does not fulfill federal requirements, as defined in 42 CFR 440.110(c), which requires a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice (i.e., licensed speech-language pathologist or licensed audiologist) to refer the student for speech and audiology treatment services. LEAs must meet both State and federal documentation requirements.

Q22. Will the Social Security Number (SSN) be accepted as an input field in the tape match request?

A. The LEA Program may ask LEAs to transmit the full social security number of their beneficiaries as long as the social security numbers are transmitted to DHCS using a Secure File Transfer Protocol (SFTP). By complying with the Data Use Agreement and its attachments, the LEA may provide the beneficiary social security number as an input field in the tape match request, and are encouraged to do so.

Q23. Can charges for billing software and license fees be included on the CRCS?

A. No, the expenses reported on the CRCS must be attributable to the direct provision of health services. Administrative expenses should be excluded from the CRCS.

Q24. Prior trainings on the CRCS process indicated that there would be an exit conference. Does the 15 day calendar notice fulfill the requirement for an exit conference?

A. An exit conference is performed in order to explain the audit adjustments to the appropriate LEA personnel after the audit is completed. Audits and Investigations (A&I) is currently conducting minimal desk audits which are primarily a reconciliation of the Units and Reimbursement reported per the CRCS and the audited per the Paid Claims Summary Report (PCSR), which is provided by the fiscal intermediary. A&I sends the 15-day-letter in lieu of an exit conference. A&I has granted more time on a case-by-case basis.

*Please refer to the LEA Medi-Cal Billing Option Training of October 7, 2011, starting with slide 123, for more details on the Audit Process.

Q25. Is the CRCS report that is due November 30th on fiscal year 2011-12?

A. The CRCS report that is due November 30, 2012 is for FY 2010/11. Please note that there is a one-time optional resubmission for FY 2009/10 CRCS forms that is also due by November 30, 2012.

Q26. For audits conducted on FY 07/08 CRCS Reports, if the LEA has questions or clarifications associated with the 15 day letter, will they receive a response prior to the issuance of the final settlement report?

A. If LEAs have any questions after they receive the 15 day letters they are encouraged to contact the Auditor who performed the audit by calling the telephone number on the 15 day letter; the 15 day letter states the name of the Auditor. If the Auditor does not hear from the LEA the draft audit adjustments will be considered accurate and an audit report will be mailed to the provider.

An appeal is different from a 15 day letter; it is the final step in the administrative process. Submitting additional documentation within the 15 day timeframe may help prevent going through the appeal process which can be time consuming.

Please refer to the LEA Medi-Cal Billing Option Training of October 7, 2011, starting with slide 133, for more details on the Audit Process.

Q27. In past training sessions, it was stated that recovery of overpayments would be deducted from future warrants. I received a letter requiring full payment, why is this?

A. The 60-day letters are sent to all Medi-Cal Providers whose final settlement results in an overpayment, except for LEAs. The office that generates the 60-day letters was not aware that LEAs overpayments do not fall under the 60-day regulation. Procedures have been implemented to ensure that LEA overpayments will be recovered from future payments, so you can ignore the 60-day letter that was sent in error.

Q28. If we are already billing in the LEA Medi-Cal Billing Option Program, do we have to submit the Annual Report and the Provider Enrollment Information Sheet every fiscal year?

A. Yes. The Annual Report is a requirement for participating in the LEA Medi-Cal Billing Option Program and each LEA is responsible for submitting an Annual Report by October 10th of each year. Since the LEA Medi-Cal Billing Option Program is affected by legislation, the terms and regulations that pertain to it may change annually.

Q29. Is it true that the PPA is now required every three years, rather than every year?

A. Effective July 1, 2012, LEAs will be required to renew the Provider Participation Agreement (PPA) every three years. The renewal is set for a fixed three year period, which is listed on page 9 of the PPA. If there is a change in regulations during the three year period, an amendment will be included in the Annual Report template.

Q30. What is required for documenting treatment services? Are these documents required to be originals?

A. Practitioners should write case/progress notes each time the student is treated and save those notes in the student's file. Each service should be documented with the student's name, date of service, practitioner type, and signature. Notes made documenting the service should be consistent with the practitioner's professional standards. Original hard-copy supporting documentation must be maintained until the auditing process for your LEA Medi-Cal Billing Option CRCS has been completed. In accordance with W&I Code Section 14170, please retain both your LEA's financial and medical records for three years from the date of submission of your CRCS forms.

Q31. What is required for an LEA to retroactively bill for TCM?

A. LEAs must submit a TCM Labor Survey form to DHCS prior to submitting LEA TCM claims. Subsequently, LEAs may submit retroactive TCM claims up to 12 months from the date of service.

Q32. If a LEA's TCM Labor Survey form was already approved and the reimbursement rate confirmation letter was issued, why are TCM claims still being denied for Medi-Cal eligible students?

A. Between late-July 2012 and October 18, 2012, LEAs may have received TCM claim denials with RAD Code 033 "The recipient is not eligible for the special program billed and/or restricted services billed." Another Medi-Cal Program update in the claims processing system impacted LEA TCM claims, causing them to deny with RAD Code 033. An EPC will be forthcoming to reprocess the denied claims.

Q33. If the initial service for speech therapy is reported on CRCS as one encounter, regardless of how many units/minutes were actually spent providing the service, why are we required to bill according to the number of units? Will this billing process be changed to allow the billing to be based on encounter? (If I bill for 30 min of speech therapy, I bill 2 units of Initial Treatment, yet we get paid the same amount regardless of number of units I bill for. Why is this?)

A. Due to HIPAA national coding requirements, LEAs must record the number of units (e.g., one, two or three units) for 15-45 minute initial treatment services when the time period is reimbursed at the same rate to accurately reflect the time it takes to complete the treatment service. For initial treatment services billed in 15-45 minute sessions, bill one unit for 15 completed minutes, two units for 30 completed minutes and three units for 45 completed minutes. There is no plan to change the billing for initial treatment services to encounter-based billing.

Q34. Should I include all FTE hours on CRCS Worksheet A-3/B-3?

A. No, the hours reported on Worksheet A-3/B-3 should reflect the annual hours the practitioner is required to work, based on the number of hours one FTE is required to work per day multiplied by the number of days the FTE is required to work per year. Annual hours exclude paid time off (holidays, sick leave and vacation time).

Q35. Why do LEAs have the option to resubmit the FY 2009/10 CRCS report? Is the revised form required for resubmission?

A. LEAs have the option to resubmit the FY 2009-10 CRCS because DHCS revised the instructions regarding the inclusion of federally funded FTE positions and "all qualified" practitioners. LEAs can review the FY 2009-10 CRCS resubmission information and LEAs must download the CRCS resubmission forms on the LEA Program website at: http://www.dhcs.ca.gov/provgovpart/Pages/2009-2010CRCSResubmission.aspx. The due date for FY 2009-10 CRCS resubmission is by November 30, 2012. Resubmissions must be completed on the revised FY 2009/10 CRCS form.

Q36. Should my LEA resubmit the FY 2009/10 CRCS report by November 30, 2012?

A. DHCS revised the FY 2009-10 CRCS instructions regarding federally funded FTE positions and "all qualified" practitioners. The FY 2009-10 CRCS resubmission is optional. If your LEA determines that the reporting differences related to the federally funded FTEs and "all qualified" practitioners are significant to your LEAs net overpayment/underpayment, you have the opportunity to resubmit your CRCS by November 30, 2012. LEAs can review the details of the FY 2009-10 CRCS resubmission and download the CRCS resubmission forms on the LEA Program website at: http://www.dhcs.ca.gov/provgovpart/Pages/2009-2010CRCSResubmission.aspx.

Q37. Where do LEAs get the reimbursement, units and encounter data to complete the CRCS?

A. For the CRCS due on November 30, 2012, LEAs may download a copy of the Interim Reimbursement and Units of Service (IRUS) Report on the LEA Program website at: http://www.dhcs.ca.gov/provgovpart/Pages/CostandReimbursementComparisonSchedule(CRCS)forFiscalYear2010-11.aspx

Q38. Are medically necessary behavior intervention services that are documented in an IEP covered and billable?

A. Currently behavioral services are not reimbursable under the LEA Medi-Cal Billing Option Program.

Q39. Our LEA utilizes the LEA Medi-Cal Billing Option Program reimbursement to help fund health practitioners who provide LEA services. Is LEA reimbursement considered to be federal funds and should these be identified in the CRCS as federal funds?

A. LEA Medi-Cal Billing Option Program reimbursement (Resource code 5640) funds are not considered federal revenues for CRCS reporting purposes. LEAs may utilize the reimbursement to fund practitioner expenditures and can report the applicable practitioner costs on the CRCS; LEAs should not report the LEA Medi-Cal Billing Option Program funds as "federal revenues".

Q40. Scoliosis Screenings are no longer a "mandate" and the law was legislatively suspended in FY 2010/11. Can these screenings now be billed?

A. State mandated screenings during the statewide periodicity schedule (including vision, hearing and scoliosis testing) may never be billed to the LEA Medi-Cal Billing Option Program. Pursuant to the Budget Act, Chapter 712, Statutes of 2010, Item 6110-295-0001, Provision 1, the legislature has suspended the operation of a mandate and reimbursement for scoliosis screenings for FYs 2010/11 through 2012/13 through the State Controller's Office. Scoliosis screenings may only be reimbursed under the LEA Medi-Cal Billing Option Program if identified as medically necessary in the student's IEP/IFSP. The treatment must meet the supervision requirements and time increment noted in section loc ed serv nurs of the LEA Provider Manual.

Q41. If a person is currently in a credential program and teaching as an intern, are they eligible to bill for TCM services?

A. If this person meets the following qualifications of a program specialist, they may be qualified to bill under the LEA Medi-Cal Billing Option Program. However, If they do not, they cannot bill for TCM services under the LEA Medi-Cal Billing Option Program. Program specialists must have a baccalaureate or higher degree from an accredited institution of higher education. These practitioners must also complete a post baccalaureate professional preparation program in accordance with requirements to qualify for a valid special education credential, clinical or rehabilitative services credential, health services credential or a school psychologist authorization. Additional qualified practitioners who may provide TCM services can be found in the LEA Medi-Cal Billing Option Program Provider Manual loc ed rend and loc ed serv targ.

Q42. For documentation purposes, is it acceptable for my LEA to present scanned documentation, or must all documentation be presented for State or federal review in its original hard-copy form?

A. Original hard-copy supporting documentation must be maintained until the auditing process for your LEA Medi-Cal Billing Option CRCS has been completed. In accordance with W&I Code Section 14170, please retain both your LEA's financial and medical records for three years from the date of submission of your CRCS forms.

Q43. For IEP students in a wheelchair who receive transportation services, can the district claim reimbursement for transportation when the student receives a treatment (i.e., nursing/speech/occupational therapy/physical therapy) when the transportation is from home to school?

A. For IEP students, reimbursement is restricted to days when the student receives a Medicaid covered service (other than transportation) and both the covered service and the transportation must be authorized in the student's IEP or IFSP. For IEP/IFSP student, transportation and mileage are currently reimbursable between home, school, and off-site covered health services.

Q44. Can the time spent traveling to a student's location to provide a treatment be added to the treatment time?

A. No, the treatment time billed should reflect the actual direct service time. The interim reimbursement rates included a travel time component when they were developed as part of the rate development process.

Q45. In regard to the new speech-language pathology credentials established by the California Commission on Teacher Credentialing (CTC), is there an exact date upon which the historical credentials are effective?

A. No, an exact date is not identified by CTC. Prior to the new credentials established by CTC, speech-language pathologists were required to have a clinical or rehabilitative services credential with an authorization in language, speech and hearing or a valid credential issued prior to the operative date of Section 25 of Chapter 557 of the Statutes of 1990. These two credentials are still valid, even though CTC added a Preliminary Services Credential in Speech-Language Pathology and a Professional Clear Services Credential in Speech-Language Pathology.

Q46. Our speech-language pathologists are all fully credentialed (5 or more years) with California State licenses. None of our staff have the Professional Clear Services Credential. Does that mean we can't bill, since we have no one to supervise?

A. Licensed speech-language pathologists do not require any supervision to provide and bill for LEA Medi-Cal Billing Option Program services. Practitioners that only hold a credential (and do not have a license) might require supervision, depending of whether they hold the Professional Clear Services Credential or the older CTC clinical or rehabilitative services credential in language, speech and hearing. Speech-language pathologists who hold the older CTC clinical or rehabilitative services credential in language, speech, and hearing may continue to provide services under the LEA Medi-Cal Billing Option Program, but must continue to be supervised by either a licensed SLP or a credentialed SLP with a Professional Clear Services Credential in Speech-Language Pathology. For more information refer to PPL 12-008 and the LEA Medi-Cal Billing Option Provider Manual loc ed rend and loc serv spe.

Q47. What is the Third Party Liability (TPL) requirement?

A. The TPL requirement is based on the basic premise that under Medicaid law and regulations, Medicaid is generally the payer of last resort. For this reason, even if services provided as part of an IEP/IFSP are exempt from the Free Care rule, they are not exempt from the TPL requirement. If any student (including those with an IEP/IFSP) has Other Health Coverage (OHC), those third party insurers must be billed prior to billing Medi-Cal for the service. OHC information is available through the eligibility tape match. For more information on the Free Care rule or the TPL requirement, refer to the 1997 Medicaid and School Health: A Technical Assistance Guide, posted on the LEA Program website at http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx.

Q48. Does my LEA need to pursue Other Health Coverage (OHC) prior to billing Medi-Cal for both IEP and non-IEP students?

A. For services authorized in a student's IEP/IFSP, Medi-Cal is still the "payer of last resort" to the student's private third party insurance coverage. If an IEP/IFSP student has third party insurance, your LEA must pursue OHC prior to billing Medi-Cal. For services not authorized in the student's IEP/IFSP, or for students without an IEP/IFSP, your LEA must additionally meet all Free Care requirements before billing Medi-Cal. This would include establishing a fee schedule, obtaining third party insurance information for the entire population receiving the service (Medi-Cal and non-Medi-Cal students), and billing OHC prior to billing Medi-Cal. Refer to the LEA Medi-Cal Billing Option Provider Manual loc ed bil (page 2) for Free Care requirements.

Q49. To meet the Free Care and Other Health Coverage (OHC) requirements, can an LEA bill a claim to Medi-Cal after billing OHC, but before it has been processed by OHC?

A. No, your LEA must receive a valid denial of non-coverage from OHC prior to billing Medi-Cal. The CMS' Medicaid and School Health: A Technical Assistance Guide (1997) provides additional guidance regarding OHC requirements. This document is available on the LEA Program website at http://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx.

Q50. If an LEA has not received LEA Medi-Cal Billing Option Program reimbursement before November 1st, will we still need to complete a CRCS report for the retro period?

A. Your LEA must complete a CRCS for any year that they are enrolled in the LEA Medi-Cal Billing Option Program and eligible to receive Medi-Cal reimbursement. The CRCS is based on the date services are provided, not when the reimbursement is received. If your LEA did not receive any reimbursement for services provided during the fiscal year, a report must be submitted that includes zero reimbursement to meet program requirements.

Q51. If an LEA is new to the Medi-Cal Billing Option Program, should they submit an Annual Report? If so, what data should be included?

A. If an LEA is new to the program, an annual report should be submitted. The LEA should check the "new provider" box under the LEA name on the annual report page and report the funds received as 0.

Q52. Please provide the definition of an LEA Billing Consortium.

A. An LEA billing consortium is when more than one LEA bills under the same NPI. The NPI listed on the PPA/AR will be that of the LEA responsible for billing and reporting for the LEA consortium. Only the member LEAs or school districts should be listed on the Consortium Billing Page.

Example 1:

- LEA Name - California COE, NPI-1234567890, EIN- 95-0000000.
- California COE includes LEA 1, LEA 2, and LEA 3, making this a billing consortium.
- All of California's COE information will go on the Medi-Cal Provider Enrollment Information Page, and the address and CDS Code for LEA 1, LEA 2, and LEA 3 will go

on the Consortium Billing Page. (The EIN for LEA 1, LEA 2, and LEA 3 is not required on the provider enrollment information sheet or the consortium page.)

- Member LEAs or school districts should be listed on the Consortium Billing Page.
    - Individual schools within a school district do not need to be included on the Consortium Billing Page.

Example 2:

- LEA Name - Capitol School District, NPI – 9876543210, EIN – 94-0000000.
- Capitol School District includes Nevada School, Phoenix School, and Union School in its district.
- This is not a consortium and the individual schools within the district do not need to be included on the Consortium Billing Page.

Q53. If an LEA is a billing consortium and billing under one LEA provider number, how should the CRCS be completed? Do the LEAs in the consortium have to be listed?

A. When multiple school districts bill with one LEA provider number, it is advisable that one draft CRCS be completed for each of the school districts operating under that provider number. Each individual CRCS should then be aggregated into a final CRCS submitted by the billing consortium. This may help ensure that costs or practitioner hours aren't excluded or double counted. LEAs are now required to report whether or not the LEA is part of a billing consortium on the CRCS Certification page. If the LEA is part of a billing consortium, the LEA must report the LEA name and corresponding County/District/School (CDS) code for each participating member of the billing consortium.

Q54. AB 2608 was passed and is effective on October 1, 2012. Are LEAs are allowed to begin billing transportation under the new law beginning October 1st?

Although AB 2608 was approved on October 1, 2012, the provisions of the bill will not go into effect until January 1, 2013. LEAs may begin billing under the new transportation regulations January 1, 2013 forward. LEAs may not bill retroactively for transportation services.